LICENSURE OF WHOLESALE DRUG DISTRIBUTORS

During the 1991 Session, the South Dakota Legislature enacted Chapter 36-11A – WHOLESALE DRUG DISTRIBUTORS, effective July 1, 1991 giving the South Dakota Board of Pharmacy authority to license wholesale drug distributors (36-11A-7) and adopt rules governing wholesale drug distribution (36-11A-14). All wholesale distributors distributing human prescription drugs subject to Section 503(b) of the federal food, drug and cosmetic act as amended through January 1, 1991, in the state of South Dakota are required to be licensed. Rules enacted by the Board of Pharmacy were established January 1, 1992 as the date of initial licensure.

Link to SDCL 36-11A and ARSD 20:67 to see current rules and regulations pertaining to wholesale drug distributors.

The following is required for licensure:

- Completed application form and fee of $200.00.
- The facility to be licensed must include a notarized copy of the home state license.
- A copy of the most recent inspection report by the licensing agency.
- Controlled Substance Registration – If your firm distributes controlled substances into the state of South Dakota, and is not currently registered with the South Dakota Department of Health, please complete the Controlled Substances Registration form, and return it to the South Dakota Department of Health.

South Dakota Board of Pharmacy
4305 South Louise Avenue, Suite 104
Sioux Falls, SD 57106
Phone: 605-362-2737 Fax: 605-362-2738

WHOLESALE DRUG DISTRIBUTOR APPLICATION – FEE $200.00

COMPLETE THE INFORMATION BELOW AS COMPLETELY AS POSSIBLE. IF NOT APPLICABLE, CHECK THE APPROPRIATE BOX. (Please Type)

The "Responsible Person" is the person located at the licensed facility who is responsible for the operation of the facility.

FACILITY LICENSED: _____

RESPONSIBLE PERSON: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ FAX: _____

This block is to be completed if different from the Facility Licensed. ( ) Not applicable

LEGAL NAME OF BUSINESS (COMPANY HEADQUARTERS): _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ FAX: _____

This block is to be completed if the contact person for licensing is different from the "Responsible Person". All licensing information and renewals will be sent to the address in this block if different from the Facility Licensed. ( ) Not applicable

NAME OF CONTACT PERSON FOR LICENSING: _____

COMPANY: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ FAX: _____

(continued on back of page)

TRADE OR BUSINESS NAMES: ("dba" names used by corporation or licensee:

_____

_____

TYPE OF OWNERSHIP: (S) SOLE PROPRIETOR (P) PARTNERSHIP (C) CORPORATION

TYPE OF OPERATION: (circle all that apply)
1. Full Service 2. Manufacturer 3. Repackager 4. Buying Group 5. Import/Export
6. Distribution Center for Multi-Unit Pharmacy Corporation
7. Other (please specify)_____

SELLS DRUGS TO: (circle all that apply)
1. Community Pharmacies 2. Hospital Pharmacies 3. Other Wholesalers 4. Veterinarians
5. Physicians or other practitioners licensed to prescribe
6. Other (please specify)_____

TYPES OF DRUGS DISTRIBUTED: (circle all that apply)
1. Controlled Substances 2. Prescription Drugs 3. Over-the-Counter Drugs
4. Other (please specify)_____

The information below must be completed by out-of-state wholesale distributors:

Please attach a notarized copy of the state license in which the facility is located and a copy of the most recent inspection report.

Home State_____ License #:_____ Expiration Date:_____

South Dakota Registered Agent:_____
(If no agent is designated, the South Dakota Secretary of State shall be considered a lawful agent for legal service.)

Information below must be completed for all applications.

CONTROLLED SUBSTANCE DISTRIBUTORS:

Federal DEA #:_____ Expiration Date:_____

SOUTH DAKOTA CONTROLLED SUBSTANCES #:_____ Expiration Date:_____

DISCIPLINARY ACTIONS – Have any disciplinary actions been taken against applicant? Yes____ No_____
(a) *Any convictions of the applicant under any federal, state or local laws relating to drug samples, wholesale or retail drug distribution, or distribution of controlled substances.*
(b) *Any felony convictions of the applicant under federal, state, or local laws.*
(c) *Suspension or revocation by federal, state, or local government of any license currently or previously held by the applicant for the manufacture or distribution of any drugs, including controlled substances.*
If yes, please list and explain on attached sheet.

CERTIFICATION

I certify that the applicant will operate in a manner prescribed by federal and state laws and rules adopted by the board. I declare and affirm under the penalties of perjury that this application has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

_____
Signature of Owner or Corporate Officer Title Date

(APPLICATION MUST BE ACCOMPANIED BY FEE OF $200.00)

Mail to: South Dakota Board of Pharmacy, 4305 South Louise Ave, Suite 104, Sioux Falls, SD 57106